Community Service Network 5 Meeting
DHHS Offices, Lewiston
March 19, 2007

Approved Minutes

Members Present:

- Julie Shackley, AHCH
- Susan Bundy, Alternative Services
- Dexter Billings, Beacon House
- Craig Phillips, Common Ties MH
- Dale MacDonald, 100 Pine Street
- Tracy Quadro, Community Mediation Services
- Ryan Gallant, ESM
- Rebecca Chandler, Evergreen/Franklin Memorial
- June Watson, Friends Together
- Scott Morrison, Lutheran Community Services
- Theresa Turgeon, Merrymeeting Behavioral
- Ron McHugh, OCMHS
- Wendy Bergeron, Possibilities Counseling
- Linda Hertell, Richardson Hollow
- Lauret Crommet, Riverview Psychiatric Center
- Ira Shapiro, St. Mary's/Sisters of Charity
- Stephanie Crystal Wolfstone-Francis, TPG
- Catherine Ryder, TCMHS

Members Absent:

- Bridgton Hospital
- Central Maine Medical Center
- Christopher Aaron Counseling Center
- Community Concepts
- Community Correctional Alternatives (excused)
- Community Rehabilitation Services
- Creative Work Systems
- Maine Vocational Associates
- Pathways Inc.
- Pottle Hill Inc.
- RM-Transitions Inc.
- Rumford Group Homes
- Rumford Hospital
- Spring Harbor
- Stephens Memorial
- Supportive Housing Associates
- Transitions Counseling Inc.

Others Present:

- Sandra Weissman, Spring Harbor
- Heather Bingelis, Richardson Hollow

Staff Present: DHHS/OAMHS: Don Chamberlain, Leticia Huttman, Sharon Arsenault. Muskie School: Elaine Ecker.

Agenda Item	Presentation, Discussion
I. Welcome and Introductions	Sharon opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the February 26 meeting were approved with one minor change.
III. Crisis Services/Crisis Stabilization Units (CSU)	Don reported that two documents from Tri-County Mental Health Services (TCMHS) had been emailed to all members: 1) CSU Additional Data Form, and 2) proposal for expansion of their CSU. He also reported that OAMHS had made the decision to add 2 beds to TCMHS' CSU. OAMHS would have preferred thorough CSN discussion before making the decision, but the timeframe (Consent Decree Plan/Court Master) would not allow it. Comments/Questions: • What is the role/function of this body vis à vis these sorts of proposals? Answer: Review and comment on whether there is a need and how it should be met. • TCMHS CSU is utilized less than 50% of the time—what can be gained by doubling size? If we continue to assign beds to urban centers, it doesn't address this wide area. More and more people are moving out of Lewiston, since it's too expensive to live here. • Oxford County Mental Health Services (OCMHS) has 80-90% occupancy all the time, which means 100% full. OCMHS sent email to OAMHS with request to increase beds from 4 to 5, with no cost to the State other than daily rate—never heard back.

Agenda Item	Presentation, Discussion
	• If utilization is only 50% in Lewiston, is it possible to add to OCMHS? Split the beds between TCMHS and OCMHS? • There's nothing at all in Franklin County—difficult to get to Lewiston, transportation is a very big issue. • Do these 2 beds mean no more in this CSN? • Is there any more funding? If not, discussion is pointless. • Don: The CSN ought to make recommendations for what is needed: identify gaps, how to solve, and move that agenda forward. • Consumer member: I often go to the ER with others (self, too), and it seems like TCMHS is always full—don't understand the 50% occupancy rate… • Continue to support development in more rural areas in upcoming planning. TCMHS plan is reasonable, worthy of moving ahead, while acknowledging needs still remain in other areas. • TCMHS: New plan allows for consumer with higher level needs to be admitted. • Is there a way to prioritize Franklin County people, since there's nothing there…streamline the process? **ACTION:** TCMHS and Evergreen Behavioral Health will meet to discuss prioritizing and streamlining the process for Franklin County admissions. **OCMHS CSU Data**: • 68 out of 91 days at 100% occupancy (April, May, June 2006). • 75 admissions; 62 unduplicated. (July 1, 2005 to June 30, 2006) • Average length of stay: 11 days • 57 from Oxford County; 6 from Franklin; 2 from Androscoggin. • 52 discharged to home; 1 to inpatient psych unit. • Seeing people who would have gone to the hospital in the past. • Greater need in Oxford County for longer stays. **TCMHS CSU Data:** • 52% of time at 100% occupancy (April, May, June 2006). TCMHS will check accuracy of this percentage. • 136 admissions; 81 unduplicated. (July 1, 2005 to June 30, 2006) • Average length of stay: 3 days • 121 from Androscoggin County; 2 from Franklin; 10 from Oxford. • 73 self-referred "Folks know how to use us." • 120 discharged to home; 4 to inpatient psych unit. • Proposed staff changes include med staff, psychiatrist, case management. Comments: • Two members questioned the lack of peer support in staff proposal. Answer: Work is in process to add this. New person on staff, Kim Lane, has this as a priority initiative. • For rural consumers, coming to the city is a frightening experience. Are we truly thinking of the provisions of Olmstead—services where consumer is? Answer: This has to be balanced against volume, need, and financial viability—some services have to work out of larger areas. • TCMHS may look to locate new facility on Franklin County side of Lewiston-Auburn area. • Franklin Memorial Hospital is considering adding two Observation Beds—perhaps have an answer on this in next couple of months.

Agenda Item	Presentation, Discussion
	ACTION: Members may send any further comments on the TCMHS CSU proposal to Chris Copeland or Catherine Ryder. **Crisis Services** The three crisis providers in this CSN reviewed their services: <u>Evergreen Behavioral Services</u> • Serves Franklin and contiguous counties. • Currently, 75-80% seen in ED—majority just show up. Working to reduce number seen in ED. • Becoming more integrated with primary care physicians. • Expanding mobile: Eustis, Rangeley, Kingfield • Staffed in overlapping shifts. Staff: MHRT/Cs, LCSWs, Nurse Practitioner, clinical specialist. • Question: Have peer services? Not yet, on peer services subcommittee to look at that. <u>OCMHS</u> • Two sites in Oxford County: Rumford, So. Paris • One staff in each location from 8 a.m. to 12 a.m.; one staff covers both locations from 12 a.m. to 8 a.m. • Work with two hospitals: Rumford Hospital and Stephen's Memorial. • Oxford County calls to statewide crisis number rerouted to OCMHS. • Improvement in coordination and ongoing care with new CSU. • Case management services will be integrated in the future. • Psychiatric consults with Evergreen Behavioral work well. <u>TCMHS</u> • Staff: MHRT/C • Vast majority are seen in ED. • Presently have 30-day stabilization model for follow-up. • Direct connection to CSU—can move past ED when appropriate. Members received copies of OAMHS Crisis Services Performance Indicator data for 2006, and Don mentioned a few areas of concern. • Number of contacts not uniformly counted provider to provider. OAMHS working with providers to resolve this issue. • Fairly high percentage of people seen by crisis don't have case managers. • Need to capture time from referral to *arrival* for assessment—shooting for 30-minute response time. (Now capturing time from referral *through* assessment.) • Where assessments are occurring—recognize people tend to go to ER in crisis—may need more education. Comments: • Raw data without percentages is useless. • Consumer members said she wants crisis services to come to her <u>home</u>. • TCMHS said often teams (ICI, ACT) are involved first, before finding it necessary to go to ED. • Will data points be defined and clearly understood by providers? Answer: Will work on this issue in CLASS/Hospital Initiative meetings.

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	Don said that OAMHS considers this CSN to have adequate coverage re: crisis services.
IV. Peer Services	Leticia reported that the peer services subcommittee was not able to meet as yet. Stephanie is working on coordinating schedules to get people together, noting that joining by conference call is an option. **Peer Support 101** Members received a handout on "Peer Support 101," a 3-hour class presented by the Office of Consumer Affairs and offered to anyone interested in learning more about peer support (also a prerequisite for participation in the Peer Support Specialist Certification program). Several classes are scheduled for March and April (listed on handout), including 100 Pine Street on March 20. Providers may request a shortened 1-hour version as well. • A consumer member expressed concerns about Peer Support 101 and also the Peer Support Specialist Certification curriculum, noting dissatisfaction with what she describes as "a blend of case management and peer support," among other things. • Leticia explained that a group of consumers, overseeing the CMS grant that funded the project, selected Shery Mead to write this 60-hour curriculum, under their advisement. • Peer Specialist Certification is required for what positions? Peer Support in the ER, warmlines, and ACT Teams (when Section 17 is reopened). • Is high school education required? Answer: No, but do require certain literacy level. • What is required—that one have a mental illness? If you asked someone who happened to have a mental illness who their peers are, they would probably mention family, friends, coworkers, etc., not someone else with mental illness. Identifying with someone else with a mental illness as a "peer" de-individualizes and stigmatizes. • Don't think this should be a paid position. Involves huge ramifications that need to be thought through. • Riverview member reviewed the much-appreciated benefits of the peer support program Amistad operates in their facility. • Members may get more information on the goals of the peer support program by attending or setting up a Peer Support 101 session.
V. Review of Community Support Services (ACT, ICI, CI)	Members received handouts of Performance Indicators Data from 2006 for the three levels of Community Support Services: Assertive Community Treatment (ACT), Intensive Community Integration (ICI), and Community Integration (CI). Don pointed out that for some providers in this CSN the number of new admissions assigned a CI case manager within 7 days of eligibility determination was not in compliance with Consent Decree. The group briefly discussed some of the reasons/barriers (staffing shortages, non-categoricals, funding, people refusing case management services). The discussion will continue at next month's meeting. Also to be discussed next month: Is there a need for more community support services in this CSN? If so, how to address.
VI. Budget Update	No update – in process.
VII. Rate Standardization	Members received a 4-page handout containing various types of information around the rate-setting. A bar graph compared Maine's highest and lowest Medicaid rate for various services and compared them to the average of New England states and other states. Other sheets listed various current rates, proposed rates, and differences, as well as the calculation process by which rates for some services may be determined.

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	Don explained that rate standardization is driven by: 1) Maine's rates are higher than other states, and 2) desire for one rate per service, not variable by agency. Don reported that at the present time in the legislative committee discussion/negotiation process, the original $10M required rate-setting savings for FY08 has been reduced to $5M, leaving $5M to be saved elsewhere (to be determined by the Legislature, if they approve). The $5M rate-setting savings is to be worked out by DHHS with providers, and there are various proposed solutions being discussed. It is premature to report anything more specific at this time.
VIII. Service Gaps: Response to Court Master Concern	Don reported on a recent meeting with the Court Master: • The Court Master appreciates the process and input of the CSNs, but will not tolerate lateness in meeting Consent Decree Plan dates on their account. • The Court Master is extremely interested in seeing that budget requests are based on identified needs, not on whether funds are available or approval is expected.
IX. Other	**Confidentiality Statement** Members again reviewed the draft Confidentiality Statement and discussed the following: • Concerned about information sharing—would help continuity of care, but still concerned about confidentiality/information sharing. • Need guidance for what agencies can do in a practical way during off-hours. • Is confidentiality required of peer supporters? Yes. • Does Dept. expect record to be available 24/7 with or without a release? No, requires preplanning with consumers to accomplish this. • Have had experience where licensing requires or recommends more "on the spot" specific releases, rather than one done in advance.
X. Public Comment	None.
XI. April Agenda Items.	Community Support Services Peer Services